THERAPEUTIC USE OF CANNABIS ADVISORY COUNCIL
Friday, October 9th, 2015, 1:00 PM
Legislative Office Building, Room 205

MINUTES

Members in attendance:

Devon Chaffee, Esq. NH Civil Liberties Union
Stuart Glassman, MD, NH Medical Society
Michael Holt, Department of Health and Human Services (Clerk)
Jill Hunter, APRN, NH Nurse Practitioner Association
Representative James MacKay (Chair)
Senator John Reagan
Andrew Shagoury, New Hampshire Association of Chiefs of Police
James Vara, Department of Justice
Richard Vincent, Qualifying Patient

Members absent:

Robert Andelman, MD, NH Board of Medicine
Lt. John Encarnacao, Department of Safety
Peter Gosline, Monadnock Community Hospital
Collette Horgan, Exeter Hospital
Representative Bill Nelson, House of Representatives
Public member – vacant
NH Board of Nursing – vacant

Call to Order

Rep. MacKay called the meeting to order at 1:12 p.m.

Council Membership

Rep. MacKay informed the Council that the Governor's office had approved the appointment of Richard Vincent, the qualifying patient representative to the Council.

Rep. MacKay announced that the public member, Kenneth Neilsen has resigned.

Review and Approval of Minutes

No review of minutes from the September 25, 2015.

Discussion on Potential Legislation

Rep. MacKay opened by summarizing the intention was to explore potential legislation. He asked Mr. Holt to start the discussion.

Mr. Holt explained that an email requesting input from the Council was sent to all members. A response was received from Jill Hunter [discussed below].

Mr. Holt distributed a copy of the Department's proposed legislation to members and the public.

The Department's first proposal would be to allow for an expansion of the definition of "providers" in RSA 126-X:1, VII(a), so that physicians and advanced practice registered nurses (APRNs) from bordering states (Massachusetts, Maine, and Vermont) would be allowed to issue written certifications for therapeutic cannabis to NH patients. Many NH citizens reside near the state borders and see primary care providers who practice in another state, and patients who are extremely ill travel out state for their care, to Mass General Hospital, in particular. Additionally, there may be barriers to access the program because NH providers may be hesitant to certify qualifying patients. Mr. Holt noted that he receives regular calls from the public on this issue. The Department also proposes to make a technical fix to the definition of "provider", to correct United States Drug Enforcement Administration (DEA) terminology from "registration" to "certification".

Rep. MacKay opened the floor for discussion on the proposal to add medical providers from Maine, Massachusetts, and Vermont, and to change the "provider" definition.

Q. Richard Vincent asked about the delay in issuing the Identification Cards. People in his support group have asked about the cards.

A. Rep. MacKay responded that this question would be answered later in the meeting.

A. Rep. MacKay next invited input from Council members with medical backgrounds.

A. Jill Hunter said she is in support of the changes because she works in home care and hospice in southern New Hampshire and many of her patients have out of state providers.

The Department's second proposal is regarding reporting provider conduct to regulatory boards. Currently there is a requirement to report to the regulatory boards in New Hampshire. This proposal will allow concerns regarding provider conduct to be referred to the appropriate regulatory entity in Maine, Massachusetts, or Vermont for an out-of-state provider.

Q. Rep. MacKay noted that it appeared complicated to report to licensing authorities in another state. He asked if there had been any calls on this issue previously.

A. Mr. Holt stated the Department cannot predict the problems that may arise with out of state providers, such as difficulty in verify providers' licenses.

Q. Dr. Glassman asked has there been any contact with the other state boards to ascertain if they would want to be involved in NH's program.

A. Mr. Holt indicated that no contact had been made with any of the states' regulatory boards.

A. Dr. Glassman questioned the effect a state's licensing board would have if it did not want to be involved. Could they say we don't want this in our state?

Q. James Vara requested verification that the other states already have medical marijuana programs in their states?

A. Mr. Holt responded that all three states did.

A. Devon Chaffee wondered why this would be an issue at all since all New England states have medical marijuana programs.

Q. Dr. Glassman inquired if there should be a specific turnaround time for reporting to licensing boards.

A. Mr. Holt stated the Department is not asking for such a legislative change and suggested that the medical professionals on the Council would be the best position to make a recommendation regarding the timeframe for reporting provider conduct.

A. Dr. Glassman indicated he would follow up with Dr. Allen, the representative from the NH Board of Medicine.

Q. James Vara added his concern that even if the other states have a medical marijuana program, what is the provider's familiarity with the NH program. For example, Maine and Massachusetts have walk-in clinics to get cards. They may not have the same standards as the NH program has in our state.

A. Mr. Holt expressed they would need to follow the requirements of our law and rules with respect to full assessment, the duration of the medical relationship, and an in-person exam. This cannot be done via the internet, and reporting concerning provider conduct to the relevant board would be a key piece.

Q. James Vara noted that the Department may report them but their standards may be different and their regulatory board might do nothing.

A. Jill Hunter noted that NH Medicaid covers different procedures than other states but providers must adhere to the requirements of the payers' state.

Q. Chief Shagoury suggested that the only way to address the issue would be to have a registry of providers who can sign the certifications, and that such a registry is a requirement in some states.

A. Mr. Holt responded that it is not part of the model that NH is currently using. Perhaps a compromise would be to have an out-of-state provider list only.

The Department's third proposal is a technical fix to a legislative change from the 2014 session regarding the Alternative Treatment Center (ATC) number being removed from the qualifying patient's registry identification card. Since the ATC number is no longer required to be listed on the id card, it is no longer necessary to issue a new card when a patient changes his or her ATC . This proposed language is simply a clean-up measure.

Q. Rep. MacKay asked Mr. Holt to answer the question that Mr. Vincent posed about the status of the registry identification cards.

A. Mr. Holt explained that the Attorney General in February of 2014 issued an advisory opinion that therapeutic cannabis cards should not be issued until there was legal cannabis available in the state, and the only source of legal cannabis is through the ATCs. The Department is abiding by that instruction and will not issue the cards until the dispensaries are open. The target for their opening is the first quarter of 2016, January through March 2016.

The Department's fourth proposal was not included in the hand-out provided. Mr. Holt introduced idea for legislation based on feedback from the ATCs regarding the quantity of seedling the ATCs are allowed to have. ATCs need to establish breeding programs for various strains. The current seedling limit is not sufficient to allow both seedlings to be used for production and seedlings to be utilized for a breeding program. Mr. Holt introduced representatives from Prime Alternative Treatment Centers of NH, to answer more questions on the issue.

A. Brett Sicklick, COO, Prime ATC, noted that Mr. Holt's comments were valid. The ATC's plant ratio is based on their patient count. There is already scrutiny to ensure that no diversion takes place, including camera surveillance and inventory counting from seed to sale.

A. Mr. Holt noted that it is a patient focused model based on the mature plants. The change would not eliminate the limits on mature plants, only on seedlings to allow for the breeding program.

Q. Rep. MacKay asked for Senator Reagan's input.

A. Senator Reagan remarked that ATCs should be able to produce the strains that they think will be helpful so that each patient has adequate amount that their medical provider recommends. Each strain has distinct therapeutic benefits and ATCs should not be constrained by a plant count at all. If patients cannot get the products they need from an ATC, they will go back to getting it off the street.

Q. Dr. Glassman stated he had heard at the last meeting that the growing was not going to be based on strains but on THC ratios.

A. Mr. Sicklick noted there is an abundance of strains with high levels of THC, and the ATCs are looking to create more strains that are lower in THC, less psychoactive, or not psychoactive at all.

Q. Attorney Vara questioned if there a need to change the law in order to allow the roll out of the program?

A. Mr. Holt responded no, the program can roll out under the current law, but the plant limits will constrain the breeding programs and the development of new strains.

Q. Dennis Action, member of the public, noted that other states have been constrained by plant counts and have quickly run out of product. He has been approached by concerned patients on this topic. He recommends supporting the ATCs to allow them to have an adequate supply.

A. Chief Shagoury stated strains may not be an accurate term as various strains can be genetically identified as substantially similar.

Q. Senator Reagan asked Mr. Sicklick to describe his organization's experience in other states.

A. Mr. Sicklick explained in Connecticut they track the success of various strains in alleviating symptoms for the patients, without using patient identifying information.

Q. Mr. Vincent asked Mr. Sicklick if there was a ratio requirement of male to female plants.

A. Mr. Sicklick explained that male plants are not used on the cultivation side because of the risk that they could pollinate the entire crop. Male plants are only be used in a breeding program.

A. Mr. Holt explained as soon as that plant becomes a mature plant it becomes part of the inventory count.

Q. Jill Hunter asked about looking at it from a medical standpoint, thinking of her patients that are naive to cannabis use. Edibles that contain multiple doses of cannabis can cause problems, e.g. who can eat one only quarter of a cookie? This can lead to a bad experience if patient ingests too much. She questioned the need to sell it in cookies, and why not just sell it as an elixir or other pharmaceutical forms.

A. Mr. Sicklick explained that Prime would be making single dose products with 5-10 mgs of THC and it would not be selling edibles. It will have metered doses in another medical form. It was his understanding that other ATCs would be selling edibles in addition to other products.

A. Mr. Holt agreed that it was his understanding that at least one of the ATCs would be selling edible products along with more pharmaceutical products.

Q. Jill Hunter asked if the products sold by the other ATCs would contain high amounts of THC.

A. Mr. Holt explained that they may contain higher doses for those extremely sick patients who need a high dose of THC. Standard dosing is 10-20 mgs of THC, but some patients require higher amounts. The rule requires the label to show the estimated time that each dose will require to take effect and the risks involved.

Q. Jill Hunter asked if there would be counseling.

A. Mr. Holt answered yes. The mantra of ATC's is to start low and go slow. There will be education at the beginning when they enroll at the ATC and ongoing.

A. Mr. Sicklick responded affirmatively as well. The ATCs will track purchases, and the feedback of all the patients. The ATCs have developed safeguards to ensure that the patients are not in an overmedicated scenario.

Q. Sen. Reagan asked that Dr. Glassman explain about a very dramatic but well-known person who reported that it takes a while for the edibles to work.

A. Dr. Glassman responded that there was an article by Maureen Dowd, a New York Times Reporter, who may not have had any of the conditions because she was going to a legal state where you can use marijuana products if you want. Bought a candy bar, took a couple of bites of it, did not feel any effects and eventually ate the entire 6 ounces. Basically her results, self-reported, had significant affects including delirium for a number of hours and associated side effects. She took more of the product that she should have.

A. Chief Shagoury noted that Prime's Connecticut dispensary does sell edibles.

A. Mr. Sicklick affirmed that is correct, because in Connecticut they only dispense not produce. Prime has to purchase from a licensed producer. They are restricted in what they sell by what the supplier produces.

A. Chief Shagoury added that there were gummy bears for example that were 300 milligrams, so they go up much higher.

Q. Dr. Glassman asked if there are different concentrations in the products.

A. Mr. Sicklick responded in the affirmative and that there can be different concentrations. Everything is clearly labeled.

Q. Chief Shagoury gave an example of a 19 year old college student who ate a whole cookie because he didn't feel any results. He ended up having a complete psychotic episode and jumping off a balcony and killing himself. That is even worse than being sick for long periods of time. He said that he didn't know anyone who eats a tenth of a cookie, even if counselled to eat a tenth. If you don't feel anything and you're looking for a certain effect, you are going to eat a cookie. He noted especially if kids come in contact with it, like the gummy bears or cookies.

Q. Rep. MacKay asked Chief Shagoury if he had any proposed legislation.

A. Chief Shagoury distributed a paper copy of suggested legislative items to the Council.

Chief Shagoury remarked edibles are an attractive nuisance to children. Cannabis should remain in the sealed container until delivered to the patient, and it should be in a locked container when transported. Similar to alcohol when open containers are not allowed.

Also, he said that he Department should be providing 24 hour access to the Registry to law enforcement. This is the model in other states with cannabis programs. It could be done through a secure portal or access points. This would answer if the card is valid for both the patient and their caregiver. Present RSA language on seizure of cannabis is also a problem for law enforcement in that only usable cannabis is allowed to be seized, and law enforcement must return seized marijuana in some cases.

The next proposed change was to reduce the amount of allowable cannabis to 2 ounces per month.

Q. Sen. MacKay asked if there were any comments from the Council on Chief Shagoury suggestions for legislation.

A. Devon Chafee responded that much of Chief Shagoury proposals appear to raise matters that were debated ad nauseam during the original drafting period of the statute. She noted that under the current law, law enforcement does not have to return marijuana that was seized due to violation of a chapter.

A. Chief Shagoury voiced his concern that under the present statute law enforcement has to decide by the side of the road what usable and unusable cannabis is. Vermont has had similar legislation to what he is proposing and it has been successfully implemented.

Q. A person from the general public questioned whether "unusable" cannabis was a hold-over from when the bill [HB573] had a home cultivation option.

A. Mr. Holt responded that it was likely a holdover from the home cultivation portion of the bill.

Q. Dr. Glassman asked about the creation of a data collection process.

A. Mr. Holt responded that the Department is interested in developing these tools. By law the patient's feedback is voluntarily given.

A. Mr. Holt asked representatives from Prime ATC the methods it would be using to encourage feedback.

A. Mr. Sicklick answered that patients at its ATC in Connecticut provide feedback and share information freely so that it will be able to provide sound data.

Q. Dr. Glassman noted that if there is five years to determine these outcomes, it will be essential to quickly get patient feedback on to the effectiveness of the program.

A. Rep. MacKay reviewed the statute with Senator Reagan. He summarized that reporting this information in a timely manner should become a priority that can be a meaningful measurement and shared with other states as well. It was decided that reporting issues would be the focus on the next Council meeting.

Motion was made by Chief Shagoury to adjourn the meeting and seconded Richard Vincent. Motion passed.

The meeting was adjourned at 2:21 p.m.

Next meeting tentatively scheduled for Friday, November 20th, 2015 at 1pm.